

# Private Health Insurance Basics 2016

## Glossary and resources



**Actuarial value:** The percentage a health plan will pay towards covered medical expenses based on a standard population. For example, in a health plan with an actuarial value of 70 percent, the consumer will pay approximately 30 percent of the total billed healthcare services and the insurance company will pay the rest.

**Adverse selection:** Occurs when less healthy people disproportionately enroll in a health insurance plan. Generally, this occurs because individuals with higher-than-average risk of needing health care are more likely to purchase health insurance than healthier individuals.

**Affordable Care Act (ACA) marketplace:** Refers to the health insurance marketplace established by states in accordance with the ACA.

**Balance billing:** Occurs when out-of-network providers bill consumers directly for the difference between the self-pay rate and the contracted rate paid under the consumer's health plan. For example, an out-of-network anesthesiologist working on a surgery may bill \$1,000, but the insurance company may only pay their contracted rate of \$250. The anesthesiologist may then balance bill the patient directly for up to \$750.

**Billable services:** Healthcare services provided to a patient that are billed to the individual or the individual's insurance company.

**Cadillac tax:** An ACA provision that implements a 40 percent excise tax on high-cost employer-sponsored health insurance coverage. The tax will be assessed on the entity providing coverage (rather than the employee), which can include health insurance issuers, employers or other entities administering plan benefits. The Cadillac tax was set to begin in 2018 under the ACA; however, Congress delayed implementation until 2020.

**Co-insurance:** A method of cost sharing in which the consumer is required to pay a defined percentage of their medical costs, often after their deductible has been met.

**Contracted rate:** The amount insurance companies agree, usually through negotiations, to pay providers for healthcare services.

**Co-payment:** A flat rate dollar amount paid by a consumer directly to the provider at the time of receiving a covered healthcare service.

**Cost sharing:** The portion of the cost of healthcare services received that consumers are required to pay. Cost-sharing expenses include co-payments, deductibles and co-insurance.

**Cost-sharing subsidies:** Subsidy to reduce out-of-pocket expenses incurred (such as co-payments, co-insurance and deductibles) for the lowest-income ACA marketplace plan enrollees. These subsidies increase the actuarial value of a health plan for the consumer.

**Coverage tiers:** The ACA requires that all qualified health plans are categorized based on actuarial value. Coverage tiers are named after precious metals and often referred to as "metal levels" of coverage.

**Deductible:** A set amount that a consumer pays during a benefit period or plan year for covered services before the insurer begins to make payment toward those covered services. Some plans cover certain services before a deductible is applied, such as preventive services. A health plan deductible does not refer to tax deductions.

**Employer shared responsibility provision:** An ACA provision that requires certain large employers with 50 or more full-time equivalent employees in the preceding calendar year to pay a shared responsibility tax (penalty) if they do not offer ESI coverage to their full-time employees and their dependents. Also referred to as the employer mandate.

**Employer-sponsored health insurance coverage (ESI):** ESI is offered by employers to their employees, and in some cases their spouse and dependents, as part of an employee's compensation package.

**Episode-based payment:** A healthcare payment model designed to pay for value in outcomes and cost across an episode of care. Episodes of care include all care related to a defined medical event. In Ohio, certain providers may share in savings if their average costs for an episode of care are below a set benchmark and quality targets are met. Providers with average costs above an acceptable level may be penalized.

**Essential health benefits:** A core set of 10 broad benefit categories outlined by the federal government that health plans sold in the individual and small group markets are required to offer.

**Federal poverty level (FPL):** A measure of income established annually by the U.S. Department of Health & Human Services. Typically income eligibility for programs and services is determined by calculating household income as a percentage of the FPL. For example, to be eligible for premium tax credits, annual household income must be between 100 and 400 percent FPL.

**Fee-for-service plans:** These plans allow plan enrollees greater choice in selecting providers and have fewer tools in place to restrict services and manage the cost of care for plan enrollees.

**Fully insured health plan:** Refers to an employer who purchases a plan from an insurance company that pays claims and assumes the risk of providing health coverage to covered employees.

**Grandfathered plans:** Refers to health plans that were in effect at the time the ACA was passed (i.e. individuals were enrolled in the health plan prior to enactment of the ACA) and that are exempt from many of the ACA reforms. Grandfathered plans have limits on the changes they can make to their plan benefit structure and requirements around employer contributions, access to coverage and cost sharing. If certain changes are made, a health plan can lose grandfathered status.

**Grandmothered plans:** Refers to health plans that can be renewed by consumers under the federal government's transitional policy outlined in 2013. The transitional policy allows certain consumers in the individual and small group markets to renew their non-ACA compliant and non-grandfathered plans through 2017.

**Group coverage:** Insurance purchased by employers or other organized groups (associations or unions). For regulatory purposes, groups are defined as small – 50 or fewer employees – or large – more than 50 employees.

**Health benefit plan:** Refers to health insurance offered by employers to employees, and may include fully insured and self-insured plans.

**Health insurance:** A contract between an individual or group and a health insurance issuer (i.e. health plan issuer), where premium payments are made to the issuer in exchange for the issuer's payment of healthcare expenses for individuals covered by the issuer's health plan (also referred to as covered individuals or health plan enrollees).

**Health insurance issuer:** Refers to a licensed health insurance company that is subject to regulation by the state department of insurance.

**Health insurance marketplace:** The ACA requires states to establish health insurance marketplaces (or exchanges) that enable eligible consumers and small businesses to compare, select and enroll in private health insurance plans. Ohio has a federally-facilitated ACA marketplace.

**Health maintenance organization (HMO):** Referred to as health insuring corporations in Ohio, individuals enrolled in an HMO are only covered for care if they see an in-network provider. HMOs have no out-of-network benefit, meaning that the consumer must pay for 100 percent of the cost of care if they receive services from a provider not within the HMO's network. In some cases, consumers enrolled in HMOs are assigned to a primary care provider. In this situation, a specialist is seen only upon receiving a primary care doctor's referral.

**Health plan:** Products sold by health insurance companies. Companies may offer several plans with different premiums, cost-sharing structures and provider networks.

**Health savings account (HSA):** A savings account that enables consumers with qualifying high deductible health plans to pay for qualifying medical expenses with untaxed dollars. A consumer can place pre-tax money into an HSA and use those funds to pay towards deductibles, co-payments and other qualifying out-of-pocket medical expenses.

**High deductible health plan (HDHP):** A health plan with a higher deductible which can typically be purchased for a lower monthly premium. The point at which a health plan becomes an HDHP is set by statute. The Internal Revenue Service issues an annual instruction that adjusts the deductible and HDHP annual out-of-pocket spending limits based on inflation.

**Hybrid group coverage:** A group health plan design that combines elements of fully- and self-insured coverage. A hybrid plan may protect an employer from some of the risk associated with self-insured plans and can be attractive to smaller employers.

**In-network provider:** A healthcare provider that is under contract with a health plan to see patients in exchange for payment at the contracted rate.

**Individual shared responsibility provision:** U.S. citizens and legal residents are required under federal law to maintain minimum essential coverage for each month of a taxable year, or be subject to a penalty. Also referred to as the individual mandate.

**Managed care plans:** Health plans that have various mechanisms in place to control the cost and delivery of healthcare services to plan enrollees including the use of provider networks.

**Minimum essential coverage (MEC):** Refers to most types of private and public health insurance coverage (e.g. Medicare, Medicaid, non-group coverage or employer-sponsored) but excludes certain coverage that provides limited benefits, such as stand-alone dental and vision insurance and limited benefit Medicaid programs.

**Narrow “skinny” network:** Refers to a health plan that has contracted with only a small number of the total available healthcare providers in the community. Insurance companies may use narrow networks as a tool to keep costs low or control the quality of healthcare services delivered to the consumer.

**Network adequacy:** Refers to whether a health plan's network contains a sufficient number of primary and specialty care providers and facilities to ensure enrollees have reasonable, timely access to healthcare services covered by a health plan.

**Network transparency:** Refers to the consumer's ability to obtain clear, accurate and easy-to-access information on providers within their health plan's provider network.

**Non-group (individual/family) coverage:** Coverage for an individual or family purchased directly from an insurance company, an insurance agent or broker, online or through a private exchange or the ACA marketplace.

**Out-of-network provider:** A healthcare provider that is not under contract with a health plan.

**Out-of-pocket expenses or spending:** Healthcare expenses that a consumer pays out of his or her own pocket, such as deductibles, co-payments and co-insurance.

**Out-of-pocket maximum:** An annual limit that is set on consumer out-of-pocket spending after which an insurer is responsible for paying all claims for covered services under the health plan.

**Patient Centered Medical Home (PCMH):** A team-based model for care delivery that includes comprehensive management of a patient's health needs through improved care coordination. Ohio's Comprehensive Primary Care program is designed to increase access to PCMH and pay for value by financially rewarding primary care practices that keep people healthy and hold down the total cost of care.

**Preferred provider organization:** Health plan designs that generally offer consumers more flexibility than HMOs because they provide an out-of-network benefit.

**Premium:** A set amount that must be paid in order to obtain health insurance coverage for a period of time. Premiums can be paid by the individual, an employer or both, and are generally paid at monthly, quarterly or annual intervals.

**Premium tax credit:** Tax credit that reduces monthly payments for ACA marketplace plan enrollees by setting a cap on an individual or family's monthly premium contribution amounts. Individuals can choose to have the credit paid directly to the health plan issuer in advance to lower their monthly premium or claim it as a refundable tax credit when filing a tax return for the year.

**Private health insurance:** Includes non-group (individual/family), small group and large group health coverage provided through an employer, another organization (such as an association or union) or purchased directly from a private insurance company.

**Provider network:** Group of healthcare providers contracted with to provide services under a health plan based on specified terms and negotiated rates.

**Public health insurance:** Includes coverage provided by a federal, state and/or local entity. Medicare, Medicaid, military and veteran coverage are examples of public health insurance.

**Qualified health plan (QHP):** With some exceptions, a plan sold on the individual and small group market must be certified as a QHP. QHPs must meet minimum standards of quality, value and benefit design.

**Reinsurance:** A temporary program for insurers established by the ACA that off-sets risks associated with the potential for greater enrollment by high-cost enrollees and reduces the incentive for insurers to charge higher premiums due to this concern. The program ends in 2016.

**Risk adjustment:** A permanent program for insurers established by the ACA that protects against adverse selection and risk selection by spreading financial risk across non-group (individual/family) and small group markets, both inside and outside of the ACA marketplace.

**Risk corridor:** A temporary program established by the ACA for insurers that stabilizes premiums and protects against inaccurate premium rate setting by health plan issuers. The program ends in 2016.

**Risk selection:** Occurs when insurers make their products less attractive to individuals with costly health conditions to avoid enrolling these individuals in their health plans.

**Self-insured group coverage:** Refers to a company that assumes the full risk of providing health coverage to its employees and pays employees' healthcare claims to providers through its own funds.

**Self-pay rate:** Consumers who are uninsured or obtain services that are not covered under their health plan are subject to a self-pay rate. Because insurance companies are able to negotiate rates with providers, self-pay rates are generally higher than health plan contracted rates.

**Small Business Health Options Program (SHOP):** The SHOP, established by the ACA, provides small employers with options for purchasing health insurance coverage in the small group market.

**Small business employer healthcare tax credit:** Small businesses may be eligible for a healthcare tax credit of up to 50 percent (for-profit) or 35 percent (non-profit) of premium contributions.

**Underinsured:** People who are insured but have high out-of-pocket costs relative to their income or ability to pay are considered underinsured.

**Uninsured:** People that do not have any type of health insurance coverage.

**Value-based insurance design (V-Bid):** A common mechanism used by insurance companies to improve health outcomes and contain costs. V-Bid aligns consumer spending on out-of-pocket expenses with the value of clinical services received.

## Resources for additional information

### Ohio Department of Insurance [insurance.ohio.gov](http://insurance.ohio.gov)

The Ohio Department of Insurance is the primary regulator for insurance companies and people that sell insurance in the state. The department provides education for consumers and investigates consumer complaints.

### Centers for Medicare & Medicaid Services (CMS) [cms.gov](http://cms.gov)

CMS is a part of the U.S. Department of Health and Human Services. CMS is responsible for administering federal healthcare programs including Medicare, Medicaid, Children's Health Insurance Program and the ACA.

### Center for Consumer Information & Insurance Oversight (CCIIO) [cciio.cms.gov](http://cciio.cms.gov)

CCIIO is an office within the Centers for Medicare & Medicaid Services. The office is responsible for administering health reforms included in the ACA. CCIIO works with state regulators to implement ACA marketplaces.

### Governor's Office of Health Transformation [healthtransformation.ohio.gov](http://healthtransformation.ohio.gov)

Created by Governor John Kasich in 2011, the Governor's Office of Health Transformation's primary goals are to modernize Medicaid, streamline health and human services programs and improve overall health system performance.

### Healthcare.gov [healthcare.gov](http://healthcare.gov)

The website that hosts the federally-facilitated ACA marketplace where consumers can go to learn about the ACA and health insurance, apply for premium tax credits and cost-sharing subsidies, purchase health coverage and report changes.

### National Association of Insurance Commissioners [naic.org](http://naic.org)

A national organization comprised of appointed and elected state officials that regulate insurance markets and providers. The organization suggests standards, shares best-practices and creates opportunities to coordinate regulatory oversight.

see all [Private Health Insurance Basics fact sheets](#) at

[www.hprio.net](http://www.hprio.net)